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Racial Differences in Preterm Delivery

**Developing a New
Research Paradigm**

Edited by
Diane Rowley
Heather Tosteson

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Foreword

Racial Differences in Preterm Delivery

Sherman A. James, PhD

This supplement to the journal features eight articles discussing various aspects of the problem of black/white differences in preterm delivery. Although each article makes a unique and important contribution, as a group, they are unified by one singularly important theme: the paradigms that currently guide research on black/white differences in preterm delivery have failed to illuminate the most important causes for the persistent black excess prevalence observed for this disorder. Furthermore, the authors argue, in the absence of a more intellectually penetrating paradigm—grounded in historical analysis as well as in the contemporary life experiences of black women—black infants will likely continue to die at twice the rate of white infants. To the authors, this is unacceptable, especially for a society that professes to value all human life equally. Recognizing the need to go beyond critique, however, these eight articles specify a creative and challenging research agenda, one that holds unusual promise for changing the way researchers think about the underlying causes of preterm delivery in black women.

In addition to their common emphasis on the need for a new research paradigm, two other themes which effectively provide specificity to the first theme are apparent. These are (1) the likely role of the *combined* effects of race, sex, and class oppression on the health of African-American women and (2) the need for researchers to establish genuine partnerships with black communities, to reduce the current high level of mutual distrust and to facilitate the grounding of research questions in the everyday life experiences of community members. With an emphasis on these three mutually reinforcing themes, I offer brief comments on several of the salient points raised in these articles.

The articles by Rowley et al., Wise, and Krieger et al. speak most directly to the underresearched *joint* influence of race, sex, and social class status on the health of African-American women. Rowley et al., for example, point out that the paradigm based on poverty—which sought to explain the greater inci-

dence of poor birth outcomes among many black mothers in terms of their social class disadvantages—advanced, to a degree, our understanding; however, this particular paradigm breaks down in the face of the elevated risks also observed for college-educated black women.¹ Since genetic factors linked to “race” are unlikely to fully explain these results, Rowley et al. describe a conceptual model that emphasizes the unique, simultaneous exposure of black women (including those of middle-class status) to both racism and sexism as the most parsimonious potential explanation of these findings. Discovering exactly how this process works—that is, how these unique social stressors affect the biological functioning of black women during pregnancy—is the main objective of the interdisciplinary program of research described in the concluding section of the authors’ article.

Krieger et al. provide a masterful analysis of the major contours of race, gender, and class oppression in advanced industrial societies like the United States. The length of the article is more than justified by the monumental intellectual effort any group of scholars must undertake in order to provide an in-depth critique of the existing research paradigm. The latter, the authors argue, not only fails to engage the concept of social class in an intellectually rigorous manner but completely ignores the corrosive effects of racism and sexism on health. Moreover, in a major departure from most reviews of this type, Krieger et al. provide clear theory-based definitions of both “racism” and “sexism” and then proceed to describe how each has interacted, historically, with social class oppression to create and maintain the current “structure of domination” that characterizes our own society and those of other advanced capitalist countries. The persistently poorer health of working-class people, as well as the manner in which race and gender exacerbate this social inequality in health, can only be understood, they maintain, if the social, economic, and political factors that reinforce the current structure of domination are illuminated through rigorous, sustained scholarly research. Pragmatically, they acknowledge that any meaningful reduction in health inequalities will not only require new theoretical (and empirical) insights into the problem but committed public health action in the political arena as well.

One final comment on the corrosive effects of sexism on the

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health of black women and black communities is warranted. As the crisis in black America deepens, prominent African-American scholars^{2,3} are speaking out with increasing directness about how sexism on the part of black men—their misguided complicity with white men to preserve male power and privilege—not only undermined the Freedom Movement of the 1960s and 1970s but, to this day, continues to add to the psychosocial stress with which black women must contend daily. Krieger et al. grasped this point with unusual clarity, and the paradigm shift which they call for exposes the health-eroding effects of all forms of oppression that affect black women, whether the source of that oppression comes from within or from outside black communities.

If, as Krieger et al. argue, “race” and “gender” are social constructions whose meanings are subject to manipulation in order to preserve nonegalitarian social structures, Wise invites readers to consider an identical proposition for “science.” The latter, he argues, is also a social construction, with judgments about what is “good” versus “bad” science, “truth” versus “falsehood” being largely a matter of what leading researchers in a given discipline can agree upon at any one time. As a deeply human activity, therefore, “science” is not invariably linked to egalitarian or progressive social movements. Naïve claims about adherence to scientific objectivity aside, “science” is frequently an unwitting partner of other ideological forces that serve to reinforce hierarchical worldviews and strengthen nonegalitarian social arrangements.

Several of the articles (Hargraves and Thomas, Hatch et al., Dressler, Gamble, and Krieger et al.) agree on the above point, but Wise argues that the deeply “social” nature of science deserves our serious attention because the antagonisms that periodically emerge, pitting advocates of “social” etiologies of disease against those who insist upon the preeminence of “biological” explanations of disease, are frequently rooted in subterranean conflicts over the relative power and prestige of various academic disciplines. This point is well worth remembering. According to Wise, most of these “either/or” perspectives on health (including infant health) are really “false” antagonisms—health is indivisibly biological *and* social.

Finally, Wise reminds us that only a relatively small percentage of adverse birth outcomes in African-American women can be attributed to ill-advised behaviors by the mother: teenage pregnancy, inadequate use of prenatal care, use of harmful substances during pregnancy, etc. Rather, the problem of preterm births among the minority of all black women who give birth is a “mainstream” affair. That is, black women who give birth to preterm babies engage in a wide variety of “appropriate” maternal behaviors and yet do not carry their babies to term. For Wise, the key explanatory factors must reside in common (i.e., “mainstream”) exposures, and this, of course, is precisely the point that Rowley et al. and Krieger et al. make.

The third and final theme concerns the potential benefits of establishing genuine research partnerships with black communities when conducting health-oriented research in these communities. This theme is implicit in the discussions by Rowley et al. and McLean et al. in their discussions of factors to be considered when developing research instruments for use with black or other nonwhite, largely non-middle-class populations. Krieger et al. also touch upon this theme in their discussion of the need to recognize and appreciate “agency” within working-class communities of color. Indeed, the very concept of “part-

nership” presupposes a mutual acknowledgment of “agency” by parties to the agreement, with each partner recognizing both the desire and the capability of the other to act with enlightened self-interest.

The most extensive and most explicit discussions of what the concept of “research partnership” entails are provided by Hatch et al. and Dressler. According to these authors, the potential benefits are clear; they include, among other things, a significantly increased likelihood that research questions will be grounded in the actual, rather than the presumed, life experiences of the study participants. Second, “disempowering” stereotypes of working-class individuals and people of color are much less likely to receive reinforcement in published articles when the research was based on the concept of a genuine egalitarian partnership. As noted in several of the articles (Rowley et al., Hatch et al., Dressler, McLean et al., and Krieger et al.), here “ethnographic” (or other qualitative) methods of research can play an important role in opening up communication and building trust between researchers and study communities. The opportunity for study participants to tell their own stories, in their own words, gives them a “voice,” indeed “empowers” them, potentially strengthening their investment in the information the study is designed to produce and the social utility of that information.

Obviously, the problems that must be confronted when researchers attempt to establish partnerships with communities are as real as the above benefits. Both Hatch et al. and Dressler, for example, warn that a struggle for control of the research agenda could occur. Resolution of this crisis will take time, patience, and a predisposition on the part of researchers to engage in “straight talk” about who will benefit from the research and when these benefits are likely to occur. It is clearly important, then, for researchers to decide beforehand if they are willing to invest, up front, the time and energy required if the benefits of a genuine partnership are to be reaped later on.

While these and other potential problems discussed by Hatch et al. and Dressler are very real, the urgent collective call for a paradigm shift expressed by authors of the articles in this issue of the journal leaves little room for continued adherence to traditional, “hierarchical” models of research, models wherein principal investigators and their staffs have little or no meaningful exchanges with communities whose health they wish to protect and improve. By raising a series of challenging questions and by sharing their insights on how some of these questions can be approached, these authors have made a distinctive contribution to our ability to “see” the problem of preterm delivery among black women in a different light. We await, with interest, empirical findings to be generated by the new research paradigm they seek to foster.

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